

**CRITERIA FOR PRIOR AUTHORIZATION**

Zolpimist® (zolpidem titrate oral spray)

**PROVIDER GROUP** Pharmacy

**MANUAL GUIDELINES** The following drug requires prior authorization:  
Zolpidem tartrate oral spray (Zolpimist®)

**CRITERIA FOR PRIOR AUTHORIZATION APPROVAL** (must meet all of the following):

- Patient must have a diagnosis of insomnia
- Patient must be 18 years of age or older
- Patient must not have a history of narcolepsy
- Patient must have a trial and failure of or intolerance to zolpidem (Ambien®) oral tablet at equivalent dose for at least 90 consecutive days of therapy in the last 120 days
- Dose cannot exceed 10 mg per day

**LENGTH OF APPROVAL:** 12 months

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

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PHARMACY PROGRAM MANAGER  
DIVISION OF HEALTH CARE FINANCE  
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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